of antral motility. The major advantage of this procedure is that gastric emptying of solids remains normal and the need for pyloroplastry or gastroenterostomy is avoided. The clinical consequence is the virtual absence after parietal cell vagotomy of dumping and postvagotomy diarrhea.

The question still in need of a final answer is how effective is parietal cell vagotomy in curing peptic ulcer disease. The preliminary reports on the incidence of persistent ulcer vary widely from over 20 percent to as little as 1 percent. The latter figure represents the experience of the group at Leeds with 300 patients followed for over six years after operation. In two randomized controlled trials recurrent ulcer after parietal cell vagotomy (2 to 7 percent) was as low as after selective (total gastric) vagotomy with a drainage procedure (2 to 5 percent). It is impossible to be certain why the failure rate has been so much higher in some units than others but there are several important technical aspects of the operation that could be responsible and perhaps with greater experience the frequency of this complication can be reduced throughout.

Results of studies of gastric acid secretion after parietal cell vagotomy show a reduction in basal output of 80 percent and in maximal (pentagastrin or histamine-stimulated) output of about 50 percent. The effect has been shown to persist for as long as five years postoperatively. Three separate reports have shown that there is no relation between preoperative levels of acid secretion and the likelihood of recurrent ulcer.

Although parietal cell vagotomy has mainly been used for the elective treatment of duodenal ulcer, it has also been tried to a lesser extent for gastric ulcer and for duodenal ulcer complicated by bleeding, perforation or obstruction. The preliminary results in these special situations are surprisingly good but much more work must be done before any judgment can be made.

In summary, parietal cell vagotomy may well be as effective as truncal vagotomy plus pyloroplasty in the treatment of duodenal ulcer and it avoids dumping and diarrhea, each of which is incapacitating in about 1 percent of patients treated by the latter technique. If these favorable results can be duplicated by surgeons generally, parietal cell vagotomy may eventually be regarded as the best operation for duodenal ulcer.

LAWRENCE W. WAY, MD

REFERENCES

Johnson D: Highly selective vagotomy. Gut 15:748-757, Sep 1974

Jordan PH Jr: Parietal cell vagotomy without drainage. Arch Surg 108:434-441, Apr 1974

ADVISORY PANEL TO THE SECTION ON GENERAL SURGERY

FRED TURRILL, MD, Section Editor, Glendale

CORRECTION

In the epitome entitled "Valium® in the Treatment of Status Epilepticus in Childhood" by Bruce O. Berg, MD, which appeared in the January issue on pages 47 and 48, a mistake has been noted in the fourth paragraph. The third sentence of that paragraph should read "Respiratory arrest has been reported during the intravenous administration of Valium, and the drug should be administered slowly and in circumstances where resuscitative emergencies can be reliably handled." A clerical error resulted in the sentence stating that "Respiratory arrest has been reported during the fourth administration of Valium . . . . "